STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 123214-001-SF**

Wayne State University
Respondent

Issued and entered
This 1st day of February 2012
by Randall S. Gregg
Deputy Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On September 1, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under Public Act No. 495 of 2006, MCL 550.1951 *et seq*.

The Petitioner is enrolled for health care coverage under the *Wayne State University DMC Care Health Plan* (WSU DMC). The plan is a local unit of government self-funded health plan under Act 495. The Commissioner immediately notified Wayne State University (WSU) of the external review request and requested the information it used to make its final adverse determination. The plan is administered by Automated Benefit Services, Inc. (ABS), which responded for WSU. After a preliminary review of the material received, the Commissioner accepted the Petitioner's request on September 9, 2011.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner's benefits are contained in the "Plan Document and Summary Plan Description" (the plan document), which is provided to covered employees. The issue here can be decided by applying the terms of the plan document. The Commissioner reviews contractual

issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On Friday, April 8, 2011, the Petitioner went to the emergency room of a hospital in XXXXX, Ohio, where she was diagnosed with cellulitis of the buttock and an abscess in the anal and rectal regions. The emergency room physician recommended follow up treatment with XXXXX, MD, and arranged an appointment for Monday, April 11, 2011. The Petitioner was discharged from the emergency room on April 9, 2011.

On April 11, 2011, the Petitioner had an office consultation with Dr. XXXXX who then performed colorectal surgery at XXXXX Hospital that same day. Neither Dr. XXXXX nor the XXXXX Hospital is part of the WSU DMC provider network.

WSU DMC covered the emergency room visit and related services at 100%. However, it processed the claims for the Petitioner's services on April 11, 2011, as out-of-network services. This left the Petitioner responsible out-of-pocket for $3,097.48 ($1,510.72 for Dr. XXXXX's services and $1,586.76 for hospital charges).

The Petitioner appealed WSU DMC's decision. At the conclusion of the internal grievance process, the Petitioner received a final determination letter from ABS dated August 26, 2011, upholding the processing of the April 11, 2011, claims.

III. ISSUE

Did WSU correctly apply the deductible and coinsurance to the Petitioner's April 11, 2011, out-of-network services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues that all the medical treatment and related services from April 8 through April 11 should be covered 100% because her condition was emergent in nature and because she was unable to obtain treatment from network providers.

The Petitioner was on her way to visit her parents when she experienced excruciating pain and went to the hospital emergency room in Toledo. She had experienced gluteal pain the week before embarking on the trip and she says she called the offices of three network surgeons and was told that the earliest she could be evaluated would be in late May or June. It was also the Petitioner's desire to be treated by a female colorectal surgeon because of her "embarrassing

and humbling" condition and she says a female surgeon was not quickly or easily available within the WSU DMC network. In an undated letter "To Whom This May Concern", the Petitioner wrote:

> … I used Tylenol and Advil for many days while I attempted to arrange an office visit with a physician that could accurately diagnose and solve my condition. After a week of failure to arrange any appointments, I decided to go home to…Ohio…. As I drove…I was forced to urgently stop at the XXXXX Hospital Emergency Department…as I could not sit any longer due to the excruciating pain I was experiencing in my buttock, perianal area as well as my abdomen.
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> * * *
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> I was seen and examined at the Emergency Department in the XXXXX Hospital by XXXXX, DO. She professionally and appropriately examined me as I feared that whatever was going on may be have been encroaching on my rectal sphincter. Upon her assessment, she felt that there was a possibility of perianal abscess, but cellulitis was definitely present. She did not feel that there was emergent involvement of the anal canal or rectal sphincter. She told me that she did not feel that there was a definitive area of fluctuance that she could drain and believed that it was in my best interest to take Bactrim and Flagyl to reduce the cellulitis and allow the area to define itself. She prescribed some pain medications and arranged for me to be evaluated by Dr. XXXXX, a colorectal surgeon on Monday April 11th in her office.
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> * * *
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> I subsequently…followed up with Dr. XXXXX in her office on April 11th. … She felt that the abscess was not amenable to incision and drainage in her office because it was simply too close to the anal area and I urgently required the operating room with anesthesia to properly tolerate the procedure. She quickly arranged for me to have incision and drainage with fistulotomy to be performed in the outpatient surgical center with anesthesia at XXXXX Hospital in XXXXX, Ohio, later that afternoon on Monday April 11th. She reiterated with me that a perianal abscess could not be properly treated in an emergency department or in her office because without discovering the fistula and performing a fistulotomy, there was a much higher risk of recurrence of the abscess. Dr. XXXXX had felt that I could have undergone without general anesthesia, however, the anesthesiologist disagreed and felt that I could not tolerate the procedure without general anesthesia. … The procedure was performed with general anesthesia at the professional discretion of physicians….
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> * * *

> My condition was not only urgent, but something that numerous "in-network" staff negligently triaged as a problem that could wait until May or June. … The only suitable outcome in my scenario is to be treated as an insured patient and provider for the DMC network by having all medical services rendered between April 8 to 11th fully covered….

Respondent's Argument

In the final adverse determination dated August 26, 2011, ABS explained its denial of network benefits:

> On page 42 of the Wayne State University Summary Plan Description, under the heading "ELIGIBLE MEDICAL, MENTAL HEALTH, AND SUBSTANCE ABUSE EXPENSES," the benefit for emergency room charges are specifically described under #12 as "EMERGENCY ROOM VISITS FOR THE TREATMENT OF AN EMERGENT ILLNESS OR ACCIDENT." This provision, #12 also provides the following, "Covered only for life threatening conditions or conditions which are the result of an accident. Emergency room treatment for a non-emergent illness will not be covered. Follow-up visits to the emergency room are not covered.
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> The Plan also defines an "Emergent Illness" on page 96: "Sever[e] symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life, or could seriously jeopardize a covered person's health if not treated immediately.
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> Your treatment at XXXXX Hospital on 4/9/11 for cellulitis and abscess of buttock and for abscess of anal and rectal regions was processed as an emergent condition, therefore the treatment on 4/11/1[1] for the same condition would not be considered as emergent per the plan provision.

WSU DMC contacted the offices of the three network surgeons that the Petitioner says told her it would be weeks before she could be seen. WSU DMC says that two of the offices indicated that requests for appointments for acute or urgent care would be accommodated within days or even on the same day, not weeks

Commissioner's Review

WSU DMC based its coverage on the network status of the provider and there is no dispute that Dr. XXXXX and the XXXXX Hospital are not in WSU DMC's provider network. The plan document's schedule of benefits clearly says that physician office visits and outpatient surgery from out-of-network providers are covered at 70% after the $500.00 out-of-network deductible has been satisfied. The Commissioner has reviewed the documentation in this matter

and concludes that the Petitioner's claims from April 11, 2011, were processed correctly.

The plan document says:

> NOTE: All eligible expenses, whether in-network or out-of-network, are subject to the DMC Care fee schedule with the exception of out-of-network treatment for Accident and Life Threatening Illness, and Mental Health and Substance Abuse Services which will be payable at Reasonable and Customary. If a provider is not participating with DMC Care (is out-of-network), the participant is responsible (if the provider requires payment) for the difference between the amount charged and the DMC Care fee schedule, even when the services are paid using the in-network percentage.

Based on the explanation of benefits (EOB) statement dated May 24, 2011, WSU DMC's scheduled fee for the Dr. XXXXX's office visit was $127.37 and its scheduled fee for the surgery was $285.87. Those amounts were credited to the Petitioner's out-of-network deductible.[1] Furthermore, because Dr. XXXXX is an out-of-network provider, the Petitioner may also be responsible for the difference between Dr. XXXXX's charges and WSU DMC's fees.

The EOB also indicates that WSU DMC paid the XXXXX Hospital facility charges at 70% as required by the plan document after $86.76 was applied to the out-of-network deductible.[2]

The Petitioner argues that her care on April 11, 2011, was for an emergency and therefore should be covered 100% under the terms of the plan document. WSU DMC does not dispute the fact that the Petitioner initially required emergency treatment in Ohio and has covered those services. However, once the Petitioner was stabilized and discharged from the emergency room, any emergency ended. At that point, if further treatment was required, the Petitioner should have followed up with a network provider. There is nothing in the record from which the Commissioner could reasonably conclude that the office visit and surgery on April 11, 2011, were required because of an emergent illness as defined in the plan document.

The Petitioner also argues that WSU DMC should cover her care from an out-of-network provider at 100% because she was unable to receive the care she needed from a network provider. However, WSU DMC disputes the Petitioner's claim that there was a one- or two-month wait for care from a network provider. It says it has three colorectal surgeons and more than 70 general surgeons in its network. Moreover, the Petitioner points to nothing in the plan document that requires WSU DMC to cover out-of-network services at the network level even if

1 The Petitioner has not argued that her out-of-network deductible had been met by the time she saw Dr. XXXXX.
2 A portion of the April 11, 2011, hospital charge ($6,353.23) was paid at 100%. The $86.76 represented the balance of the Petitioner's $500.00 deductible.

the care was not available within its network.

The Commissioner finds that the care in dispute was follow-up care rather than emergency care and was provided by an out-of-network provider. Nothing in the plan document or state law requires WSU to cover that follow up care at 100%. The Commissioner finds that WSU DMC correctly processed the claims for the Petitioner treatment on April 11, 2011.

V. ORDER

The Commissioner upholds WSU DMC's final adverse determination of August 26, 2011. WSU DMC is not required to cover the services of Dr. XXXXXX and XXXXX Hospital at 100%.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Randall S. Gregg
Deputy Commissioner